

Figure 1 Blood lymphocyte counts in patients with perforated diverticular disease ($P < 0.01$, Tukey test).

SIR,—All patients were afebrile by the fifth postoperative day. The single exception to this pattern was an individual with multiple inflamed perforated diverticula that were discovered at laparotomy. After initial surgery, he required further resection of necrotic tissue. This patient's lymphocyte count remained below $1 \times 10^9/l$ for 16 days (P2 in figure). All patients had normal chest radiographs before their operation; thus, lymphopenia was not attributable to adult respiratory distress syndrome, in which there is widespread margination and extravasation of white cells to lung vessels together with extravasation of fluid. Lymphopenia seems to be a reversible component of the disease associated with bowel necrosis, as seen in appendicitis.¹ By contrast, the more global picture of leucopenia in diverticulitis is associated with generalised peritonitis in those cases with high morbidity and mortality.² Lymphocytopenia could be secondary to either massive systemic effects of bacterial endotoxin and cytokines,³ or that the lymphocyte count may be worthy of more attention than it usually receives.

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Celiac disease and lymphoma

SIR,—We believe that some of the misunderstanding (Aug 3, p 318) relating to Professor Wright and colleagues' report (June 8, p 1373) results from a failure to distinguish clearly between neoplasia and malignant disease. Two years ago we pointed out that the term "lymphoma" is generally applied to malignant lymphoid tumours but that there are also benign B and T cell neoplasms that have gone unrecognised in the past because the neoplastic cells are mature and morphologically normal and, like their normal counterparts, mingle with other cells without producing sharply

defined tumour masses. Unregulated functional activity of such neoplasms can lead to immunopathological disturbances and to histopathological appearances that masquerade as chronic inflammation.¹ The principle may apply to celiac disease, as we originally suggested.² The finding in cells of the relevant clone of chromosomal or molecular abnormalities at the level of growth-cell neoplasia hypothesis would provide further evidence in favour of the T-cell neoplasia hypothesis in patients without overt malignancy.

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Treatment of inflammatory bowel disease with anti-CD4 monoclonal antibody

SIR,—The aetiology of Crohn's disease and ulcerative colitis is unknown. The efficacy of corticosteroids and immunosuppressive agents suggests a central role for inflammatory mediators in their pathogenesis. The increased expression of class II histocompatibility antigens on colonic enterocytes¹ and considerably lymphocyte activation² indicate that the immune system of the gut is hyperreactive in inflammatory bowel disease. The monoclonal antibody (mAb) MAX.16H5 has been used successfully in the treatment of severe rheumatoid arthritis.³ We have therefore investigated the therapeutic effect of MAX.16H5 directed against the CD4 surface molecule on helper T-cells in 3 patients with chronic active steroid-resistant or steroid-dependent inflammatory bowel disease. Diagnosis of Crohn's disease or ulcerative colitis was based on endoscopic, radiological, and histological criteria. In the present study, a dose of 0.3 mg/kg MAX.16H5 was infused on each of seven consecutive days. 1.5 g prednisolone were maintained throughout the observation period. Patient 1 was a 47-year-old man with a 10-year history of Crohn's disease and extensive perianal fistulae. Previous treatment with sulphasalazine, mesalazine, prednisolone, azathioprine, and metronidazole was ineffective. In the past year, he had had severe flare-ups whenever prednisolone was reduced below 30 mg daily.

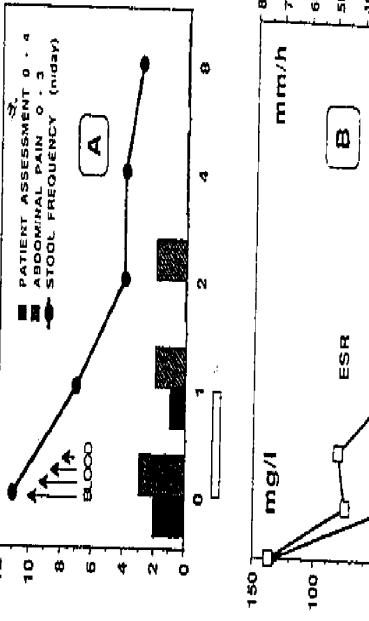


Figure 2 Clinical (A) and laboratory (B) data in patient 3 with ulcerative colitis. Daily infusions of 0.3 mg anti-CD4 mAb (MAX.16H5) per kg body weight for 7 days (open bars).

His Crohn's disease activity index (CDAI)* was 177 and systemic indices of inflammation were raised (erythrocyte sedimentation rate (ESR) 167 mm/h, orosomucoids 2.7 g/l, C-reactive protein (CRP) 88.6 mg/l). He improved rapidly, had no pain, and stools were normal for three weeks after anti-CD4 treatment. ESR fell to 45 mm/h, orosomucoids to 1.8 g/l, and CRP to 38 mg/l. After four weeks, he had a mild relapse, which responded to a higher dose of prednisolone (20 mg).

Patients 2 and 3 both had a longstanding history (6 and 9 years, respectively) of severe left-sided ulcerative colitis, with multiple relapses despite appropriate maintenance therapy. Both had had chronically active disease for more than six months. Moderate improvement was only seen at more than 30 mg prednisolone per day. Patient 2 responded to anti-CD4 treatment clinically, and by a transient reduction of CRP, but relapsed after one month. Patient 3, however, has had complete clinical, endoscopic, and biochemical remission (figure) for more than five months.

Inflammatory bowel disease, T cells in the lamina propria may represent an unusual stage of differentiation, and they seem to be hyperresponsive⁵; this might contribute to local inflammation. In our study, treatment with MAX-16H5 led to a substantial and immediate depletion of CD4 cells from the circulation in all patients as has been shown in rheumatoid arthritis.³ Anti-CD4 treatment also induced striking immunomodulation, as shown by reduced lymphocyte proliferation on stimulation with various mitogens and recall antigens. A transient reduction of the density of CD4 molecules on the surface of helper T cells was also seen. Whether or not these observations are part of the mechanism of action of this therapy is unknown. It is noteworthy that CD4 depletion could be detected to the same extent and with the same kinetics in both responders and non-responders to anti-CD4 therapy who had rheumatoid arthritis.³

None of our patients had side-effects from antibody treatment. Our findings demonstrate that such therapy can be successful in inflammatory bowel disease when conventional drugs have failed. A single cycle of anti-CD4 at the doses we used is not sufficient to persistently suppress disease activity in all patients. Prolonged or repeated courses of antibody therapy or in combination with immunosuppressive drugs should be considered.

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Pancreatitis associated with *Salmonella* enteritis

SIR,—After the letter from Dr Renner and colleagues (June 29, p 1611), who suggest that pancreatitis is common in salmonellosis, we describe our own experience. We have recently completed a retrospective review of all 34 adults admitted to our hospital with non-typhoidal salmonella gastroenteritis between January, 1982, and June, 1989. The commonest isolates were *Salmonella*

typhimurium (44.5%) and *S. enteritidis* (27 (7.1%); 27 (17.1%) of the 158 patients who had blood cultures taken were bacteraemic. Complications were noted, but serum amylase estimations and abdominal ultrasonography were rarely completed and were not systematically recorded in our review. None of the 34 patients had clinically apparent pancreatitis.

Since July, 1989, we have prospectively studied adults admitted to our unit with acute gastroenteritis. Patients thought to have toxin-mediated food poisoning, at the time of admission, were excluded from the study protocol, which includes at least two blood cultures and estimation of serum amylase on admission, but does not routinely include sonography. The distribution of causative pathogens is representative of patients admitted to our unit with gastroenteritis¹ and the commonest salmonella isolates were *S. enteritidis* (46.5%), and *S. typhimurium* (17.2%). None of the patients had clinically apparent pancreatitis. Serum amylase activities (normal range 10-96 IU/l) that were available for 147 of 171 patients are summarised below:

Pathogen ²	Age (years) mean (SD)		Serum amylase (IU/l) mean (SD)
	n	mean (SD)	
None isolated	63	43.6 (19.5)	37.6 (22.4)
Salmonella	51	37.7 (19.3)	33.5 (18.9)
Campylobacter	22	40.1 (18.4)	32.2 (21.7)
Miscellaneous	11	43.6 (17.1)	30.1 (16.7)
Total	147	41.1 (19.2)	34.8 (20.7)

There was no difference (Kruskal-Wallis) in the mean amylase activities among the salmonella group compared with the campylobacter group, or between the salmonella and campylobacter groups combined compared with all other pathogens. Slightly raised amylase activities were found in only 1 patient with salmonella (110 IU/l) and in 3 with no pathogen isolated (98, 112, and 135 IU/l). None of the 5 bacteraemic salmonella patients had a raised serum amylase. Our findings contrast with the 62% of patients with salmonella reported by Renner et al and the high frequency of campylobacter isolates reported by others,² all of which have been associated with raised amylase and lipase activities. Although cases of severe pancreatitis associated with campylobacter infections have been reported,^{3,4} this complication appears to be rare. We agree that an infective cause should be thought of in a patient with abdominal pain, diarrhoea, and hyperamylasaemia in the majority of patients with infective gastroenteritis.

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Healing of cavity wounds with sugar

SIR,—Your April 27 editorial discusses the use of sugar paste as formulated by us. We were surprised by Professor Parish and Professor Witkowski's (June 1, p 1355) dismissal of the use of sugar as a treatment for the healing wound.

The safe and effective application of ordinary granulated sugar to infected wounds has been recorded previously in *The Lancet*.^{1,2} We have formulated cauter sugar (fine granular sucrose) and ionic sugar peroxide into thick and thin pastes.³ We have shown these pastes to be non-toxic to healing wounds in a controlled trial in the domestic pig.⁴ The effects of sugar paste on water activity and bacterial growth in vitro have been investigated.⁵ Within wounds, these sugar pastes reduce the available water and this inhibits bacterial growth; however, they still allow granulation tissue to form and